

ADMISSION AND EVALUATION DATA

Date: _____ Medicare Admission Date: _____

TO: Alabama Medicaid Agency
P. O. Box 5624 – 36103
501 Dexter Avenue
Montgomery, Alabama 36104

Medicaid Admission Date: _____
Medicaid Discharge Date: _____
Date of Death: _____

FROM: _____
(Name of Facility)

Provider Number _____

(Address of Facility)

Telephone Number _____

Patient's First Name _____ M.I. _____ Patient's Last Name _____ Female ____ Male ____

_____/_____/_____, Birthdate _____

Social Security No. ____ - ____ - ____ Medicaid No. ____ - ____ - ____ - ____ - ____ - ____

Diagnosis and Pertinent Medical Information (Continue on Back)

List all Medications to include: Route, Dosage, Time, Treatment, Diet:

Listed below, but not limited to, are specific services that a resident requires on a regular basis.

- ☐ A. Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.
- ☐ B. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
- ☐ C. Nasopharyngeal aspiration required for the maintenance of a clear airway.
- ☐ D. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
- ☐ E. Administration of tube feedings by naso-gastric tube.
- ☐ F. Care of extensive decubitus ulcers or other widespread skin disorders.
- ☐ G. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (provide supporting documentation).
- ☐ H. Use of oxygen on a regular or continuing basis.
- ☐ I. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
- ☐ J. Comatose resident receiving routine medical treatment.

I certify this resident requires nursing facility care effective
on the admission date appearing on this form.

Physician's Signature (Physician Must Sign)

Facility Registered Nurse Reviewer Signature

Physician's Address

☐ New Admission ☐ Spend Down

☐ Re-Admission

☐ Transfer Admission From: _____

[illegible]